MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04576

4586

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Mar Port
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mar Port
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
JOSEPH	BRADLEY	BAKER	May	22	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Col	Widowed	July 8, 1890	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Farming		Md	U S A

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
James B	Eliza Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	220-28-6176	Clarence Baker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Cerebro vascular occlusion	2 weeks
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) hypertension	10 years
DUE TO		
	(c) arteriosclerosis	20 years

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Jan., 1955 to 22 May 1955, that I last saw the deceased alive on 20 May, 1955, and that death occurred at 6:45 a.m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Frederick M. Johnson	M.D.	La Plata Md	22 May 55

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/25/55	St Joseph	Morganza Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5/24/55	Julia H. Casey	Brehmer Funeral Home	Leonardtown Md.

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04577

MARYLAND STATE DEPARTMENT OF HEALTH

4587

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 105

1. PLACE OF DEATH: COUNTY CHARLES — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WALDORF, — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Chas
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf, Md.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) BROCK (Middle) (Last) BUTLER
4. DATE OF DEATH: (Month) MAY (Day) 25 (Year) 1955
5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) divorced
8. DATE OF BIRTH: 1913
9. AGE last birthday: 42 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): labor
10b. KIND OF BUSINESS OR INDUSTRY: odd job
11. BIRTHPLACE (State or foreign country): charles Co.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: John Butler
14. MOTHER'S MAIDEN NAME: Georgra Lankers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT AND ADDRESS: Lennie Green Washington, D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
420.1
Immediate cause (a) Coronary Occlusion — Interval between onset and death: 5-25-55
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0 — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE C. Hebden (Degree or title) M.D. ADDRESS La Plata Md DATE SIGNED 5-26-55

23. DISPOSITION: Burial — DATE THEREOF 5/26/55 — NAME OF CEMETERY OR CREMATORY Woodlawn Mem. Gdns. — LOCATION (City, town, or county) Waldorf — (State) Md

DATE REC'D BY LOCAL REG. 5.26.55 — REGISTRAR'S SIGNATURE M. L. Mercer

24. FUNERAL DIRECTOR Hunt & Tyson — ADDRESS Waldorf, Md

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

04578

4588

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Charles; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock Point; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock Point; STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED (Type or Print): (First) JOCKLIN (Middle) L. (Last) BUTLER

4. DATE OF DEATH: (Month) 5 (Day) 24 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): S

8. DATE OF BIRTH: 4-18-55

9. AGE last birthday: yrs. If under 1 year: Months; Days: 7. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Daniel Butler

14. MOTHER'S MAIDEN NAME: Evelyn Edelen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Evelyn Butler, Rock Point, Md.

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 491X Bronchopneumonia — Interval Between Onset and Death: 5-21-55

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ; (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE C. Edelen (Degree or title) MD ADDRESS La Plata Md DATE SIGNED 5-24-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF 5/30/55; NAME OF CEMETERY OR CREMATORY Holy Ghost; LOCATION (City, town, or county) Issue; (State) Md.

DATE REC'D BY LOCAL REG. 5/30/55; REGISTRAR'S SIGNATURE Julia A Posey; 24. FUNERAL DIRECTOR Prichard Funeral Home Inc; ADDRESS La Plata

2045265393

VS. A15A

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

4589

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04579

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY Charles MARYLAND
Physicians mem Hosp
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata, Charles Co Mem
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians mem Hospt

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Port Tobacco
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) HOWARD (Middle) E (Last) CRISMOND

4. DATE OF DEATH: (Month) May (Day) 7 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: April 8 1921
9. AGE last birthday: 34 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator Bull Dozer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Stafford Co Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John R Crismond
14. MOTHER'S MAIDEN NAME: Elsie L Best

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 226-14-0214
17. INFORMANT & ADDRESS: John R Crismond Sr. 438 Dorchester ave Crombridge

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 600.0

		Interval Between Onset and Death
Immediate cause (a)	Uremia & anuria	3 days
DUE TO (b)	chronic pyelonephritis	over 10 years
DUE TO (c)		

Antecedent cause(s): Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-25, 1955, to 5-6, 1955, that I last saw the deceased alive on 5-6, 1955 and that death occurred at 2 55 P. m., from the causes and on the date stated above.

SIGNATURE Frederick M. Johnson (DEGREE OR TITLE) M.D. ADDRESS La Plata, Md DATE SIGNED 5-9-55

23. BURIAL, CREMATION REMOVAL (Specify): Removal
DATE THEREOF May 7 1955
NAME OF CEMETERY OR CREMATORY Andrews Chapel
LOCATION (City, town, or county) Stafford Co (State) Va

DATE REC'D BY LOCAL REG. 5-10-55
REGISTRAR'S SIGNATURE Julia H Posey
24. FUNERAL DIRECTOR Orehart Funeral Home Inc
ADDRESS Laplata md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04590

4590

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY CHARLES — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN X LA PLATA
LENGTH OF STAY (in this place): LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS 66 PHYSICIANS' MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY CHARLES
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LA PLATA WALDORE X 1
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) BARBARA (Middle) JEAN (Last) DAUGHERTY

4. DATE OF DEATH: (Month) MAY (Day) 7 (Year) 1955

5. SEX: FEMALE

6. COLOR OR RACE: W-U.S.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: MAY 4, 1955

9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months, Days 3½ — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD

10b. KIND OF BUSINESS OR INDUSTRY: CHILD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ROY FRANKLIN DAUGHERTY

14. MOTHER'S MAIDEN NAME: ELIZABETH ANN GARDINER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT & ADDRESS: ROY F. DAUGHERTY WALDORE, MARYLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

7543

Immediate cause (a) CONGENITAL CARDIAC DEFECT - PATENT FORAMEN OVALE - HYPERTROPHY OF RIGHT AURICLE AND RIGHT VENTRICLE — Interval Between Onset and Death: 3½ DAYS

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b)
DUE TO (c) ATALECTASIS, RIGHT LUNG — 3½ DAYS

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. PASSIVE CONGESTION - LUNGS, LIVER, SPLEEN

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/4, 1955, to 5/7, 1955, that I last saw the deceased alive on 5/7, 1955, and that death occurred at 1.10 P.M. EST, from the causes and on the date stated above.

SIGNATURE John H. Griffin (DEGREE OR TITLE) M.D. ADDRESS Hughesville Md DATE SIGNED 5/7/55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 5-8-55 — NAME OF CEMETERY OR CREMATORY St Peters Cemetery — LOCATION (City, town, or county) Waldorf, Md (State)

DATE REC'D BY LOCAL REG. 5/8/55 — REGISTRAR'S SIGNATURE Julia A Carey

24. FUNERAL DIRECTOR Hoath & Ryon — ADDRESS Waldorf, Md

2055273415

4591

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04581

CERTIFICATE OF DEATH

Reg. Dist. No. 100

Medical Examiner's Code

1. PLACE OF DEATH:

COUNTY Charles — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Joseph	Preston	Dorsey	5	16	19 55

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday: yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	C	M	6-29-25	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer		U.S.A.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jimmy Dorsey	Rebecca Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Yes 1946	241-26-7681	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Cong Heart Failure — Interval between onset and death: 5-16-55

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary tuberculosis (Found at autopsy)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
			M.		

22. I hereby certify that I attended the deceased from May 19 to May 16, 19 55, that I last saw the deceased alive on May 16, 19 55, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE C. Edelen M.D. (DEGREE OR TITLE) ADDRESS La Plata Md DATE SIGNED 5-16-55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-19-55	Holy Ghost	Doane Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5/18/55	Julia A Geary	Ambert Funeral Home	La Plata Md

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04582

4592

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Chas MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Mem. Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Chas

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head

STREET ADDRESS (If rural, give location) 116 Circle Ave

3. NAME OF DECEASED: (Type or Print) (First) Wm (Middle) P (Last) HENDERSON

4. DATE OF DEATH: (Month) 5 (Day) 22 (Year) 19 55

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Widowed	9-5-90	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Spring Powder factory

10b. KIND OF BUSINESS OR INDUSTRY: U S Govt.

11. BIRTHPLACE (State or foreign country): Va

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Henderson

14. MOTHER'S MAIDEN NAME: Mary Cortes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Maggie A Taylor Indian Head Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
591.0 **Immediate cause**	(a) Bronchial Pneumonia	5-21-55
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Cirrhosis of Liver	1954
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 6

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-20, 19 55, to 5-22, 19 55, that I last saw the deceased alive on 5-22, 19 55, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) C. D. Edelen MD ADDRESS La Plata Md DATE SIGNED 5-22-55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-25-55	Bethel Cemetery	Alexandria Va

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5/23/55	Julia B. Posey	Hewitt & Tyson	Waldorf, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

04583

4593

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Randolph (Middle) Preston (Last) Johnson

4. DATE OF DEATH: (Month) May (Day) 24, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Mar. 8, 1955

9. AGE last birthday: yrs. If under 1 year: Months 2 Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Wash. D. C.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Ralph Johnson

14. MOTHER'S MAIDEN NAME: Victorine Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Victorine Johnson, La Plata, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchial Pneumonia — Interval Between Onset and Death: J-21-55

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diarrhea — J-23-55

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the date stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED 5-24-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 5-25-55 — NAME OF CEMETERY OR CREMATORY: St. Marys — LOCATION (City, town, or county) (State): Bryantown, Md.

DATE REC'D BY LOCAL REG. 5/24/55 — REGISTRAR'S SIGNATURE: Julia H Wasey

24. FUNERAL DIRECTOR ADDRESS: Ralph Johnson, La Plata, Md.

9V35 19V19V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

4594

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04584

CERTIFICATE OF DEATH

Reg. Dist. No. 100

Item 7, Film G182, 5/27/55 fcy

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X La Plata
LENGTH OF STAY (in this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 66 Physicians Mem Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata X
STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED: (Type or Print) (First) Louisa (Middle) (Last) KNOCH.
LOUISA

4. DATE OF DEATH: (Month) MAY (Day) 10, (Year) 19 55

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 10-5-1888

9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? Germany

13. FATHER'S NAME: Unk

14. MOTHER'S MAIDEN NAME: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs Viering La Plata, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

155X

Immediate cause (a) Acute congestive heart failure — Interval Between Onset and Death: 1 hr.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Hepato-renal failure — 1 day

DUE TO

(c) Adeno-Carcinoma of ~~Liver~~ Gall Bladder with metastasis — 6 Months

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10 May 55 **19b. MAJOR FINDINGS OF OPERATION:** Adeno-Carcinoma of Gall bladder with metastasis **20. AUTOPSY?** Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 May, 19 55, to 10 May, 19 55, that I last saw the deceased alive on 10 May, 19 55, and that death occurred at 6 25 P.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Frederick M. Johnson M.D. — ADDRESS La Plata, Md. — DATE SIGNED 10-May-55

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation — DATE THEREOF May 11 1955 — NAME OF CEMETERY OR CREMATORY Cedar Hill — LOCATION (City, town, or county) (State) Scotland Maryland

DATE REC'D BY LOCAL REG. 5/20/55 — REGISTRAR'S SIGNATURE Julia H. Posey

24. FUNERAL DIRECTOR Hunts & Ryon — ADDRESS Waldorf Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4595

CERTIFICATE OF DEATH

04585

Reg. Dist. No. 07

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Charles — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Rison — LENGTH OF STAY (in this place): 20 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: DD

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md — COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rison X

STREET ADDRESS (If rural, give location): 1

3. NAME OF DECEASED: (Type or Print) (First) Matilda (MATILDA) (Middle) — (Last) Manduc (MANDUE)

4. DATE OF DEATH: (Month) May (Day) 3 (Year) 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Negro	Widow		88 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Rison Md.	U S

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
# NO		—	(Half-Brother) Joe Smallwood Rison Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause — (a) 422.2 Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/28, 1955, to 5/3, 1955, that I last saw the deceased alive on 4/28, 1955, and that death occurred at 4:30 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Frank L Susan M D — ADDRESS Indian Head, Md — DATE SIGNED 5-3-55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	May 7, 1955	Alexander Chapel	Chicamuxen	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5-3-55	Mary Southerland	Montgomery Bros - 913-14th Ave NW	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04586

4596

CERTIFICATE OF DEATH

Reg. Dist. No. 102

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Nanjemoy
LENGTH OF STAY (in this place) 75 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Nanjemoy

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Charles.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nanjemoy X
STREET ADDRESS (If rural, give location) 1 Nanjemoy

3. NAME OF DECEASED: (Type or Print) (First) Kate (Middle) (Last) Marbury

4. DATE OF DEATH: (Month) May (Day) 23 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: April 1880

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Nanjemoy Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Lawson.

14. MOTHER'S MAIDEN NAME: Sarah (?) Lawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) # (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Kate Berry, Nanjemoy, Md (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Coronary Occlusion	Immediate
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Hypertensive Heart Disease	3-4 yrs
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Pernicious Anemia — 4-5 yrs

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 5?, 19..., to May ..., 19 55, that I last saw the deceased alive on May 21, 19 55, and that death occurred at 5:30 A m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Frank A Anderson M.D — ADDRESS Indian Head, Md — DATE SIGNED 5-23-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 5-26-55 — NAME OF CEMETERY OR CREMATORY Oak Grove Baptist Church — LOCATION (City, town, or county) Nanjemoy (State) Md

DATE REC'D BY LOCAL REG. May 25 1955 — REGISTRAR'S SIGNATURE D V Thompson

24. FUNERAL DIRECTOR Penny & Cofer — ADDRESS Wilson Springs Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4597

04587

Reg. Dist. No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Part Tobacco — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Part Tobacco
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) Berry (Last) OLIVER.

4. DATE OF DEATH: (Month) May (Day) 1st (Year) 19 55

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: Oct. 1, 1888

9. AGE last birthday: 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: James Oliver

14. MOTHER'S MAIDEN NAME: Mary C. Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Mary E. Oliver, Part Tobacco, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1
Immediate cause (a) Coronary occlusion. — Interval between onset and death: 30 sec.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Coron. arter disease. — 1 year.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) — (Day) — (Year) — (Hour) — M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 40, to May, 19 55, that I last saw the deceased alive on May 1, 19 55, and that death occurred at 4:35 p.m., from the causes and on the date stated above.

SIGNATURE J. Woodall. (DEGREE OR TITLE) MD. ADDRESS La Plata. Md. DATE SIGNED 2 May 55.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 5-4-55 — NAME OF CEMETERY OR CREMATORY St. Ignatius — LOCATION (City, town, or county) (State) Hilltop, Md.

DATE REC'D BY LOCAL REG. 5/2/55 — REGISTRAR'S SIGNATURE Julius A Wasey

24. FUNERAL DIRECTOR Wehrt Funeral Home — ADDRESS LaPlata, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04588

4593

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct item is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LaPlata — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Proctor

4. DATE OF DEATH: (Month) May (Day) 15 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: 5-15-55

9. AGE last birthday: yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours 4, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Sidney Swann

14. MOTHER'S MAIDEN NAME: Frances Lavena Proctor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ? (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Frances L. Proctor, Waldorf Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

97.5

Immediate cause (a) Respiratory collapse — DUE TO — Interval Between Onset and Death: 10 min

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) prematurity. — DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 May, 1955, to May, 1955, that I last saw the deceased alive on 15 May, 1955, and that death occurred at 12:5 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

A Woodard MD LaPlata Md 16 May 55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 5/16/55 — NAME OF CEMETERY OR CREMATORY St. Peters — LOCATION (City, town, or county) (State) Waldorf Md

DATE REC'D BY LOCAL REG. 5/16/55 — REGISTRAR'S SIGNATURE Julia H Causey

24. FUNERAL DIRECTOR Hunt & Bryan, Waldorf Md. — ADDRESS

2055183310

4599

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04589

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH: COUNTY Charles MARYLAND; CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) LaPlata; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 66 Phy. Mem. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) MARVETTA (Middle) (Last) STEWART

4. DATE OF DEATH: (Month) 5 (Day) 18 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 9-29-74

9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Charles Co Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Porter

14. MOTHER'S MAIDEN NAME: Sarah Roach

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: George E. Stewart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) 443X Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1-11-55

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Hypertensive Heart Disease

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-11, 1955 to 5-18, 1955, that I last saw the deceased alive on 5-18, 1955, and that death occurred at 10.30 P.m. from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) R. J. Edelen M.D. ADDRESS LaPlata Md DATE SIGNED 5-18-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF May 21 1955 — NAME OF CEMETERY OR CREMATORY St Mary's — LOCATION (City, town, or county) (State) Bryantown Md

DATE REC'D BY LOCAL REG. 5/20/55 — REGISTRAR'S SIGNATURE Julia H Casey

24. FUNERAL DIRECTOR — ADDRESS Talbert Funeral Home Inc LaPlata Md

46 0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04591 181

tem 2, Film 183 6-29-55 et

1. PLACE OF DEATH: CHARLES
COUNTY Cha- Co — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Phy. Mem. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Chas
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Grayton
STREET ADDRESS (If rural, give location) ---

3. NAME OF DECEASED: (First) Le Myell (Middle) (Last) WASHINGTON

4. DATE OF DEATH: (Month) 5 (Day) 7 (Year) 1955

5. SEX: M

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 4-27-1874

9. AGE last birthday: 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: MAE C. WASHINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) N — (If Yes, give war or dates of service) NO

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause — (a) Acute Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Arteriosclerotic Cardiovascular Disease — 1 yr.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-7-, 1955, to 5-8, 1955, that I last saw the deceased alive on 5-8-55, 19..., and that death occurred at 6:10 A.M., from the causes and on the date stated above.

SIGNATURE Dayton Parker M.D. — (DEGREE OR TITLE) — ADDRESS La Plata Md — DATE SIGNED 5-8-55

23. BURIAL, CREMATION, REMOVAL (Specify): Buried — DATE THEREOF 5-10-55 — NAME OF CEMETERY OR CREMATORY: Oak Grove - Riverside, Md. — LOCATION (City, town, or county) (State): Riverside Md

DATE REC'D BY LOCAL REG. 5-10-55 — REGISTRAR'S SIGNATURE: Mary Sutherland

24. FUNERAL DIRECTOR: Penny & Cooper — ADDRESS: Pisgah, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH

04592

46^1

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata — LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 66 Phy Memorial Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Waldorf — X
STREET ADDRESS (If rural, give location) /

3. NAME OF DECEASED (Type or Print): (First) ANDREW — (Middle) W — (Last) WILLIAMS JR
4. DATE OF DEATH: (Month) 5 (Day) 9 (Year) 1955

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single | 8. DATE OF BIRTH 6-7-43 | 9. AGE last birthday 11 yrs. | If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Charles Co Md | 12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Andrew Williams Sr | 14. MOTHER'S MAIDEN NAME Mary Moreland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY No. none | 17. INFORMANT AND ADDRESS Mary Moreland Waldorf Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
936.6 Immediate cause (a) Acute respiratory failure	5-4-55
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Hemorrhage	5-6-55
(c) Hit by baseball in head	5-6-55
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION / 19b. MAJOR FINDINGS OF OPERATION / 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Field | CITY OR TOWN Waldorf | (COUNTY) Chas | (STATE) Md

TIME OF INJURY (Month) 5 (Day) 6 (Year) 55 (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? Hit in head by baseball

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE R Hedden (Degree or title) MD ADDRESS La Plata Md DATE SIGNED 5-9-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 5/12/55 | NAME OF CEMETERY OR CREMATORY St Peters | LOCATION (City, town, or county) Waldorf | (State) Md

DATE REC'D BY LOCAL REG. 5/12/55 | REGISTRAR'S SIGNATURE Julia H Haney | 24. FUNERAL DIRECTOR Hunt & Ryon | ADDRESS Waldorf Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04593

4692

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY CHARLES MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HUGHESVILLE (RURAL) X

LENGTH OF STAY (in this place) LIFE

~~HOSPITAL OR INSTITUTION~~ OR STREET ADDRESS GILBERT SWAMP ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY CHARLES

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HUGHESVILLE (RURAL) X

STREET ADDRESS (If rural, give location) GILBERT SWAMP ROAD

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
LOUIS	MAGUIRE	WOODLAND JR.	MAY	1	1955

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	NEGRO-U.S.	SINGLE	DECEMBER 10, 1953	1 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
CHILD	NONE	MARYLAND	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
LOUIS MAGUIRE WOODLAND, SR.	ALICE ELIZABETH NEALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
NO	—	NONE	LOUIS M. WOODLAND, SR. HUGHESVILLE, MARYLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
492X Immediate cause	(a) PNEUMONITIS, RIGHT LOWER LOBE AND LEFT LOWER LOBE	17 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) TOXIC MYOCARDITIS	24 HOURS
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
0	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—	—	—

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
— M.	—	—

22. I hereby certify that I attended the deceased from APRIL 18, 1955, to MAY 1, 1955, that I last saw the deceased alive on APRIL 30, 1955, and that death occurred at 6:25 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

John N. Griffin M.D. HUGHESVILLE, MD. 5/2/55

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5-2-55	St. Mary's Cemetery	Bryantown Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
5/2/55	Julia H Haney	Hunt & Ryon, Waldorf, Md.